OUTPATIENT INFANT HEARING SCREENING PROVIDER APPLICATION

Name of facility/individual			
Name of administrator			
Medi-Cal provider number	NPI number		
Service address	City	ZIP code	County
Telephone number	FAX		
Mailing address (if different from above)	City	State	ZIP code
Contact person for this application			
Telephone number	FAX	E-mail	

TYPE OF FACILITY (check one)

☐ Newborn Hearing Screening Program-approved Inpatient Infant Hearing Screening Provider

☐ California Children's Services-approved Hearing and Speech Center

☐ Ambulatory health care facility or provider office *(If checked, please complete the following.)*

Individual responsible for supervision of outpatient infant hearing screening services:

☐ CCS-Paneled Pediatrician

☐ CCS-Paneled ENT

☐ CCS-Paneled Family Practice Physician

☐ CCS-Paneled Audiologist

TYPE OF HEARING SCREENING EQUIPMENT TO BE USED (for newborns and infants):

TEOAE	DPOAE
Automated ABR	ABR
Other	

Manufacturer	Model	Serial Number

Please attach a copy of the documentation from manufacturer that the equipment can detect a mild, 30–40 dB, hearing loss.

STAFFING

Name of the person responsible for overseeing the outpatient infant hearing screening services *(Please attach a copy of the Curriculum Vitae.)*

List the names and positions of all personnel who will perform screenings:

Name	Position
Name	Position
Name	Position
Name	Position
Name	Position

Name of the person responsible for training *(Submit Curriculum Vitae and indicate when/how individual was trained on infant hearing screening equipment)*

This application is submitted with the understanding that the facility/individual will comply with the terms contained in Standards for Outpatient Infant Hearing Screening Providers, Chapter 3.42.2. In addition, the facility/individual will provide documentation of procedures the facility will use to support the activities identified in Sections C.4 Care Coordination/Referral and C.5 Reporting Requirements, if requested. The signature below certifies that the facts in this application are true and correct to the best of the signator's knowledge.

Authorized Signature

Title	Date

MAIL THE COMPLETED APPLICATION AND ALL NECESSARY DOCUMENTS TO:

Attention: Unit Manager
Hearing and Audiology Services Unit
Children's Medical Services Branch, MS 8103
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413